

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-004190

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District

1003

Registrar's No.

159

STATE FILE NUMBER

FILED JAN 16 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

St. Louis

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)

Homer G. Phillips

Inside Limits

Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Missouri

b. COUNTY

St. Louis

Inside Limits

Yes ☐ No ☐

d. STREET ADDRESS

(If outside, give location)

5336 Northland

Reside on Farm

Yes ☐ No ☐

3. NAME OF DECEASED

(Type or print)

First

Grace

Middle

Tate

Last

4. DATE OF DEATH

Month

Day

Year

1

4

63

5. SEX

Female

6. COLOR OR RACE

Negro

7. Married ☐ Never Married ☐Widowed ☒ Divorced ☐

8. DATE OF BIRTH

2-8-90

9. AGE (last birthday)

72

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

NONE

11. BIRTHPLACE (City and state or country)

MISSISSIPPI

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

ARCHIE FERGUSON

13b. MOTHER'S MAIDEN NAME

MATTIE GRESSON

14. NAME OF HUSBAND OR WIFE

DECEASED

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

LOUISE YOUNG 5336 NORTHLAND

18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Shock

INTERVAL BETWEEN ONSET AND DEATH

Undet.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Cerebral Thrombosis

DUE TO (c)

332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Bronchopneumonia

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

12-29-62

to 1-4-63

and last saw her alive on 1-4-63

Death occurred at

4:45 p.

m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Signature or title)

22b. ADDRESS

2601 N. Whittier

22c. DATE SIGNED

1-5-63

23a. BURIAL, CREMATION, REMOVAL (Specify)

REMOVAL

23b. DATE

1-10-63

23c. NAME OF CEMETERY OR CREMATORY

WASHINGTON PARK

23d. LOCATION (City, town, or county)

ST. LOUISCTY.

MO.

(State)

24. FUNERAL DIRECTOR

ADDRESS

THOMAS JACKSON 2741 DICKSON ST

25. DATE RECD. BY LOCAL REG.

JAN 7 1963

26. REGISTRAR'S SIGNATURE

Boad Smith, M.D.

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer.

Signed

Leroy W. Bonmeister

Licensed Embalmer No. 4523

P. O. Address 4251 Washington

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.